CHILD CARE ASSISTANCE PROGRAM

CHILD CARE ASSISTANCE APPLICATION

Use this application to apply for child care assistance benefits for children under 13 years of age, or for children 13 years of age up to 19 years of age who have a developmental disability.

For Office Use Only
Date Received

PLEASE PRINT CLEARLY

APPLICANT INFORMATION The applicant is the person who is requesting child care assistance.

Last Name	First Name, Middle Initial	Social Security Number (optional)	
Physical Address	City	State	Zip Code
Mailing Address	City	State	Zip Code
Home Telephone / Email Address		Marital Status	Other Names You Have Used

HOUSEHOLD INFORMATION List each person living with you in your household, starting with yourself.

Last Name	First Name, Middle Initial	Date of Birth	Relationship to You	Gender M / F	U.S. Citizen* (Yes or No)	Ethnicity (optional)	Race (optional - check all that apply)
			SELF			❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ Alaska Native ❑ American Indian ❑ Black or African American ❑ Asian ❑ Native Hawaiian or Other Pacific Islander ❑ White
						❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ Alaska Native ❑ American Indian ❑ Black or African American ❑ Asian ❑ Native Hawaiian or Other Pacific Islander ❑ White
						❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ Alaska Native ❑ American Indian ❑ Black or African American ❑ Asian ❑ Native Hawaiian or Other Pacific Islander ❑ White
						❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ Alaska Native ❑ American Indian ❑ Black or African American ❑ Asian ❑ Native Hawaiian or Other Pacific Islander ❑ White
						❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ Alaska Native ❑ American Indian ❑ Black or African American ❑ Asian ❑ Native Hawaiian or Other Pacific Islander ❑ White
						❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ Alaska Native ❑ American Indian ❑ Black or African American ❑ Asian ❑ Native Hawaiian or Other Pacific Islander ❑ White

* Provide a copy of the alien identification card (front and back) for each child that is not a U.S. citizen.

PROVIDER INFORMATION

The provider you select must be either licensed or otherwise approved to participate in the Child Care Assistance Program. The provider's full name is not required if you will be using a child care center.

Last Name		First Name, Middle Initial	
Facility Name		Telephone Number	Fax Number
Physical Address	City	State	Zip Code

HOURS OF CARE

For each child, list the times during each day that care is needed. Use the NOTES page if more space is needed.

Child's Name:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From: ______	From: ______	From: ______	From: ______	From: ______	From: ______	From: ______
To: ______	To: ______	To: ______	To: ______	To: ______	To: ______	To: ______

Child's Name:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From: ______	From: ______	From: ______	From: ______	From: ______	From: ______	From: ______
To: ______	To: ______	To: ______	To: ______	To: ______	To: ______	To: ______

Child's Name:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From: ______	From: ______	From: ______	From: ______	From: ______	From: ______	From: ______
To: ______	To: ______	To: ______	To: ______	To: ______	To: ______	To: ______

Child's Name:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From: ______	From: ______	From: ______	From: ______	From: ______	From: ______	From: ______
To: ______	To: ______	To: ______	To: ______	To: ______	To: ______	To: ______

INCOME INFORMATION	List money you or anyone in your household receives from employment, including self-employment. Please provide proof. Do not include money belonging to a child under 18 years of age.				
Name of Person Employed	Employer	# of hours worked	Monthly Gross Income	How Often Received	Do you expect this to change?
		/ month			
		/ month			
		/ month			
		/ month			

OTHER INCOME	List any other money you or anyone in your household receives (not including income listed above). Please provide proof. Do not include money belonging to a child under 18 years of age.			
Name of Person Receiving Income	Source of Income	Amount Received	How Often Received	Do you expect this to change?

CHILD SUPPORT EXPENSES Only legally obligated child support payments may qualify as a deduction. Please provide proof.

Does anyone in your household pay child support to someone outside of the home? ❑ Yes ❑ No Amount: $_____ per _____

MEDICAL / DENTAL EXPENSES Only ongoing payments for allowable medical and dental expenses may qualify as a deduction. Please provide proof.

Does anyone in your household have medical or dental insurance payments? ❑ Yes ❑ No Amount: $_____ per _____

Does anyone in your household have any other ongoing medical or dental payments? ❑ Yes ❑ No If yes, please explain below:

ELIGIBLE ACTIVITIES	Eligible activities include work, seeking work and participation in approved education or training programs. Use the NOTES page if more space is needed.			
Name of Person in Activity	Type of Activity (work / education / training)	Activity Schedule (A or B) completed below	Date Activity Began	Anticipated Date of Completion (if applicable)

ACTIVITY SCHEDULE A	List the times during each day the person participates in the activity.					
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From: _____ To: _____	From: _____ To: _____	From: _____ To: _____	From: _____ To: _____	From: _____ To: _____	From: _____ To: _____	From: _____ To: _____

ACTIVITY SCHEDULE B	List the times during each day the person participates in the activity.					
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From: _____ To: _____	From: _____ To: _____	From: _____ To: _____	From: _____ To: _____	From: _____ To: _____	From: _____ To: _____	From: _____ To: _____

STATEMENT OF TRUTH

Under penalty of perjury of unsworn falsification, I certify that the statements made on this application and during my interview for assistance regarding the persons in my home, my household income, participation in eligible activities, and all other items that pertain to my possible eligibility for child care assistance are true and correct to the best of my knowledge.

I have read, or had read to me, and understand my rights and responsibilities as described on page 7 of this application.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Other Adult Applicant Date

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the release of information requested by the Department of Heath & Social Services, its grantees, or its agents within the Department of Law. The requested information will only be used in the administration of the Child Care Assistance Program, and will not be released to any other person or agency outside the Department of Health & Social Services, its grantees, or its agents within the Department of Law.

This release of information will be in effect while I am an applicant or participant of the Child Care Assistance Program, and for any later investigations pertaining to my eligibility and program benefits.

Persons or organizations that may be contacted include, but are not limited to, the Department of Law, the Department of Labor, the Department of Revenue, the Immigration and Naturalization Service, the Alaska Housing Finance Corporation, the Social Security Administration, local governments, public assistance program contractors and grantees, Native corporations, landlords, employers, school authorities, and private individuals.

A COPY OF THIS RELEASE IS AS VALID AS THE ORIGINAL

Your Signature	Signature of Other Adult Household Member
Printed Name	Printed Name
Social Security Number	Social Security Number
Address	Address
Phone Number	Phone Number
Date	Date

NOTES

YOUR RIGHTS AND RESPONSIBILITIES

Social Security Numbers

Social Security Numbers are optional in accordance with 45 CFR 98.71(a)(13). Social Security Numbers are not required for child care assistance eligibility. Eligibility may not be denied or withheld due to the failure of the applicant to provide a Social Security Number. When provided, Social Security Numbers are used to collect research data sets that do not identify specific individuals.

Your Rights

You have the right to discuss any action taken on your application or case with your caseworker or with your caseworker's supervisor.

Administrative Reviews

If you disagree with a determination made by the local child care assistance office, you may request an administrative review of the determination to the Department of Health & Social Services Child Care Program Office. You can do this by submitting a Request for Administrative Review form, along with all required documentation, within 15 working days of the date you received the notice of determination from the local child care assistance office. Send your request to:

Child Care Program Office
619 E. Ship Creek Avenue, Suite 230
Anchorage, AK 99501-1665

Hearings

If you disagree with a decision made on a request for an administrative review, you may file a notice of appeal and request a formal hearing on the decision of the Child Care Program Office. You can do this by submitting a request for hearing in writing to the Department of Health and Social Services within 15 calendar days of the date you received the decision from the Child Care Program Office.

Civil Rights

Federal laws and regulations prohibit discrimination or the denial of participation on the basis of race, color, national origin, religion, sex, age, handicap or political beliefs in programs receiving federal financial assistance.

Americans with Disabilities Act of 1990

The Alaska Department of Health & Social Services and its grantees comply with Title II of the Americans with Disabilities Act of 1990.

Your Responsibilities

As a participant in the Child Care Assistance Program you must:

- Notify your local child care assistance office within seven days following an income change in excess of $200 a month, or any other change that would affect your family's program benefits or eligibility;
- Give your provider at least 14 days' written notice of your family's intent to terminate child care except:
  - In the case of sudden program ineligibility;
  - In the case of an allegation of abuse, harm, or serious risk of harm to a child in the provider's care; or
  - Upon mutual agreement between the provider and yourself.
- Pay the portion of authorized child care costs not paid on your behalf;
- Renew your child care authorization in a manner timely enough to provide for continuity of care;
- Review the provider's monthly billing statement to verify that care was billed only for hours of eligible activity; and
- Pay for child care costs if alternative care arranged during an unscheduled facility closure is unreasonably refused.

Penalty Warnings

Erroneously Obtained Benefits

If the local child care assistance office determines that there is reasonable evidence you erroneously obtained benefits, steps shall be taken to reduce or withhold payment, to establish a repayment schedule, or to take other corrective action, as necessary, including probation, suspension or termination from the program.

Erroneously obtained benefits means program benefits received by a family that the family was not entitled to or that were received while in noncompliance with a program requirement.

Program Sanctions

Your participation in the Child Care Assistance Program may be placed on probation, suspended, or terminated for any of the following reasons:

- Failing to report complete, accurate, and current information regarding family income and eligibility;
- Failing to keep family income and eligibility information current with the local child care assistance office;
- Failing to comply with family responsibilities for participation in the program;
- Providing false or misleading information or withholding information in order to participate or receive benefits under the program;
- Agreeing with a provider to falsify attendance records to reflect higher amounts of time that a child was in care than was used;
- Refusing to cooperate with a review or investigation by a representative of the department or grantee regarding eligibility for benefits or provision of services by a participating provider under the program; or
- Failing to comply with any compliance action or corrective action plan or to cooperate with the establishment of the plan.

This information on this page is based on State regulations at 4 AAC 65.

APPLICATION CHECKLIST

✓ Check to be sure you have submitted the following documents!

- ❑ The completed and signed application.
- ❑ A copy of your valid, government issued photo identification.
- ❑ Copies of official birth certificates for each child who will be receiving child care assistance.
- ❑ Proof of alien status for each child who will be receiving child care assistance, if not a U.S. citizen.
- ❑ Proof of child support paid, if applicable.
- ❑ Proof of ongoing medical and dental payments, if applicable.
- ❑ Proof of all income received by you and anyone in your household, excluding children under 18 years of age. This includes wages, tips, self-employment income, dividends and interest, payments from Native corporations, Social Security, Supplemental Security Income (SSI), child support, and any other earned or unearned income.
- ❑ For self-employed individuals only, a copy of the most recently completed federal tax return and income and expense records.

Please ask your local child care assistance office about what form of proof is acceptable if you are unsure.

Submit this application along with all required documentation to: